Post Event Summary Report

Challenges to Health and Long-Term Care
Rebalancing Long-Term Care: Principles and Recommendations
for a National Health and Long-Term Care Strategy

An Independent Aging Agenda Event of the 2005 White House Conference on Aging

Date of Event: April 25, 2005

Location of Event: Holiday Inn, East, St. Paul, Minnesota

Number of Persons Attending: 300

Sponsoring Organization: Minnesota Board on Aging

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Priority Issue #1:
Minnesota, like other states, will experience significant demographic shifts over the next 15-20 years, specifically resulting in larger numbers of older and often frailer residents as the Boomer cohort retires and moves into old age. These changes, along with generally smaller families (one third fewer children per couple than their parents' generation), and fewer people living in each household, will inevitably lead to more strain on family caregiving resources, and a greater need for individuals to pay for the "formal" support services. Historically low savings rates among the Boomer cohort increase the likelihood that a great number of them will not be able to privately purchase the services and supports they will need. How will the support needs of this generation be met? What should the health and long-term care system in the future look like?

In the past five years Minnesota has begun the work of transforming an out-dated and unsustainable long-term care system. This system is based on the notion that long-term care is either passively custodial in nature OR that it is like medical care and can be provided in brief, episodic interactions. But growing prevalence of multiple chronic illnesses is testing these assumptions, giving rise to new ways to better manage multiple chronic illnesses and improve quality of life over an extended range of abilities. In addition, the present system is heavily institutionalized, and the highly regulated environment requires that significant resources be spent on paperwork rather than direct health care/support.

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Barriers:
At the state level, and with the aid of state waivers for federal programs, Minnesota has begun to "rebalance" its long-term care system by shifting public expenditures from institutional settings to supporting people in their own homes and communities. But as it is currently designed the fundamental system does not deliver what people want and need, nor is it a system we can afford in the future. In order to continue to make progress in Minnesota and to meet emerging population needs, we will need to make two changes at the national level: fundamentally redesign the basic benefit set to address the multiple chronic care needs of tomorrow's older population and to stress the kinds of interventions that help people help themselves; and to rethink funding strategies, including a re-assessment of public/private responsibility for long-term care.

In order to frame our national thinking about the changes that are needed, we must develop consensus around the basic policy directions that should guide these changes. The following four policy directions have emerged in Minnesota as fundamental to developing effective and sustainable national long-term care policy:

1. Help people help themselves: Ultimately the future demand for long-term care can be influenced by individual choices today. People need information to help them understand their choices, including liability and risk, and to make better plans for their own futures.

2. Address the emerging health care needs of an aging population**.** Old age is characterized by an increase in chronic illnesses and changes in activity and function that result from them. Federal policies (Medicare and Medicaid) were designed to address *acute illness.* Over time, numerous waivers have been applied to the Medicaid program so that it can effectively serve low-income persons with chronic, long-term care needs. However, no parallel "system" is available to persons who are not very low income. Medicare is under pressure today to better address needs of persons with multiple chronic illnesses (e.g., prescription drugs), but there is much more that should be done.

3. Acknowledge family and informal caregiving. Family caregivers and informal supports continue to provide the vast majority of long-term care in Minnesota and the United States, although demographic and economic trends may be eroding this resource. The public sector can not replace the care currently provided by informal caregivers; however, there are ways to support and better complement this resource.

4. Acknowledge the importance of community. Not all support for older persons comes (nor should it come) from health/long-term care programs. Community supports include supportive/affordable housing, a basic, underpinning necessity to stabilize older persons' lives; transportation (more important as LTC becomes more decentralized); and informal, faith-based and other quasi-formal community supports.

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PRINCIPLES FOR HEALTH AND LONG TERM CARE REFORM

In addition to these policy directions, there are some basic principles that should guide the development of reform proposals.

1. Universality: We need a universal approach in order to forge a coherent national system. ***All workers*** should be saving and preparing for old age – it is just as important as Social Security. ***All ages*** should invest in improved health (and reduced need for health care) -- particularly focused on prevention. We want today's kids to become healthy adults and, eventually, healthy older persons. ***All states*** should have compatible systems – a national plan is necessary to ensure portability from state to state (for both private and public products).

2. Personal responsibility: If we want to help people help themselves, the system must promote personal responsibility and provide mechanisms and incentives to balance personal/individual responsibility with public responsibility.

3. Flexibility: Interventions are maximally effective if they are tailored to individual needs. Consumers must be involved in developing a *benefit package* that is designed to meet unique individual needs and to complement an individual's unique strengths and resources.

PROPOSED SOLUTIONS FOR CREATING A NATIONAL LONG-TERM CARE STRATEGY:

1. Reduce the future need for long-term care

We need a national strategy to reduce disability and improve physical/mental function of Americans across the lifecycle. This will pay off in improved productivity among the U.S. workforce and reduced future disability and dependence among the elderly.

- ✓ A national health and long-term care policy must include incentives for disease prevention and good health.
- ✓ It must address the entire population, providing appropriate goals across the life cycle. Planning for long-term care when one is approaching retirement is too late.

2. Restructure National Health/Long-Term Care Strategies

We need to change the ways that we pay for health and long-term care services. Health and long-term care is neither a purely private market nor purely public arena. A new partnership between public and private funding is in order. We also need to change the way we provide health and medical care to realistically meet the changing needs of the population.

A. New ways to pay for health and long-term care

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- ✓ Create a new mechanism, a Personal Health Savings Account. Whether part of Medicare or Social Security or a private entity, we need a mechanism to allow workers to accrue savings so that they will be able to pay for their own health/support services and long-term care.
- ✓ The mechanism should be universal. ***All*** employees contribute a percentage of their wages to this account, and it accumulates over time.
- ✓ Funds that accrue in the account can ***only*** be spent on health and long-term care needs: whether (a) direct care services, (b) health or long-term care insurance, or (c) for an Individual Long-Term Care Plan (see below). Unlike the current Health Savings Account, the savings accumulate over a person's earning's lifetime.
- ✓ The contribution is from pre-tax dollars (like deferred compensation), and there is no tax on interest earned by the account.
- ✓ The funds in the account belong to the individual. Funds that are not expended in the person's lifetime may be passed on to heirs—however, the heir/s will be required to pay all deferred taxes if they liquidate the account, but NO tax if it is rolled over into a new Health Savings Account for the heirs.
- ✓ Public-Private Partnerships for long-term care financing have been developed by several states (e.g., Partnership for LTC Program, New York Compact and Hawaii's proposed universal savings program) to eliminate the all-or-nothing approach of today's entitlement programs and to provide incentives for individuals (or their private insurance) to put up the first dollar, and the public puts up the second dollar.
- ✓ Reduce burden on individual businesses for health coverage by allowing states to create business insurance-pools – both for risk-pooling and for health care purchasing.

B. New Benefit package We can no longer pretend that we can meet the future population's needs with a national strategy based on an acute care model. Nor can we afford to continue to separate acute care from long-term care (both parts of health care). Whoever the purchaser (whether the individual, government or third party/insurance) the following should apply:

- ✓ A universal *triggering event* for long-term care should be an objective functional assessment.
- ✓ When you need LTC, the following are available to you:
  - Your own LTC Savings Account
  - Your own insurance (see below)
  - Medicaid
- ✓ The long-term care benefit is not a service, but an ***individualized care plan*** developed between the consumer and a care coordinator.
- ✓ The benefit includes ***care planning/coordination*** to work with the consumer, their family and the health/support providers *to develop and implement the individualized care plan*.

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- ✓ For low-income older Americans (the so-called "dual-eligibles") Medicare and Medicaid benefits must be integrated—through an individual care plan. As has been demonstrated with the Minnesota Senior Health Options program, eliminating the cost-shifting incentives, produces better outcomes and higher consumer satisfaction

C. Create New Private Insurance (including Medigap) Products. Private insurance products today are designed primarily as indemnity plans. New products should be developed to complement public programs in re: personal responsibility, and flexibility.

- ✓ All Medigap policies must include the services of care coordinator/navigator to help develop/ authorize the *individual care plan*.
- ✓ Eligibility should be triggered by same objective functional assessment as Medicare/Medicaid.
- ✓ The benefit set is implementation of the Individualized Care Plan, developed between consumer and an authorized care coordinator/navigator. The services may be paid for from (a) the individual's Personal Health Savings Account and/or (b) the third-party insurance company.

3. Supportive Communities:

The physical and economic infrastructure of the community provides the "foundation" or supporting persons throughout the life cycle.

- ✓ HUD – Basic Service Coordination should be available in all public housing. Low-income persons are more likely to be facing multiple issues, including poverty, physical and/or mental disability, and lack of strong social support network. Good management skills for working with these populations include service referral to needed community supports. To help elderly tenants to age in place Service Coordination should be available every day.
- ✓ DOT – National transportation policy must include strategies to improve the safety for a nation of older drivers. Coordination between public transportation and so-called "Special transportation" is essential.
- ✓ AoA – (a) The role and value of family caregiving and informal, voluntary and faith-based supports cannot be overestimated. AoA must identify and strengthen support for evidence-based programs that maintain and improve these community resources. (b) In order to make good decisions, people must be able to understand their options and to have reliable and objective information about the alternatives. AoA must continue to find ways to raise public awareness about the issues of aging and provide effective mechanisms to help people help themselves, and ensure equitable access to community resources.
- ✓ NIH – Research is needed to establish evidence about cumulative outcomes for the care of common chronic conditions (and clusters of chronic conditions) over time and across care settings/professionals. Quality outcomes should not be limited to the distance between the front door and the back door of a given care setting when chronic conditions are involved.

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